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Medicare and Prepayment Plans

- **Health Maintenance Organizations**
- **Competitive Medical Plans**

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- **Health Maintenance Organizations**
- **Competitive Medical Plans**

Medicare beneficiaries can get health care services from a variety of sources of their own choosing. Among these sources are a growing number of prepayment plans that have contracts with the Federal government to provide services to Medicare beneficiaries. These include Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs). This pamphlet is intended to answer most of your questions regarding the advantages and limitations of receiving your care through HMOs and CMPs.

Prepayment plans might be thought of as a combination insurance company and doctor/hospital. Like an insurance company, they cover health care costs in return for a monthly premium, and like a doctor or hospital, they furnish health care. Since they provide health care for a fixed prepaid amount, prepayment plans seek to minimize their costs by contracting with specific doctors and other health care providers, and by emphasizing efficiency, preventative care and the early treatment of illness.

WHAT SERVICES DO PREPAYMENT PLANS OFFER?

Prepayment plans with Medicare contracts must offer at least all benefits covered by Medicare that are generally available in their areas. (For a list of Medicare benefits see ***The Medicare Handbook***, which is available from any Social Security office.) Medicare makes a monthly payment to the plan to provide you with all of Medicare's benefits. Because the payment does not cover Medicare's deductibles and coinsurance, you may be required to pay the plan a monthly premium and/or copayments to cover these costs.

Also, some plans provide benefits beyond what regular Medicare covers. If a plan provides extra benefits, it may impose an additional charge.

The new and improved Medicare benefits provided by the Medicare Catastrophic Coverage Act of 1988 will be made available to you whether you are in "regular" Medicare or enrolled in a prepayment plan. The phasing in of the new and expanded benefits started January 1, 1989. (For an explanation of the catastrophic and other Medicare benefits see ***The Medicare Handbook***.)

There are two basic types of prepayment plans:

- Those operating at one or more centralized locations
- Those operating through individual doctor's offices

If you live in an area that is served by more than one prepayment plan, you should compare benefits, costs, and other features to determine which plan best suits your needs.

MUST I CONTINUE TO PAY THE MEDICARE PART B MEDICAL INSURANCE PREMIUM?

Yes, you're required to have and pay for Part B of Medicare to be a Medicare-member of a prepayment plan. The Part B monthly premium ($31.90 in 1989) is usually deducted from your Social Security or Railroad Retirement check.

Medicare Part B helps pay for medically necessary doctor services, outpatient hospital services, home health care, and various other medical services and supplies not covered by the hospital insurance part of Medicare (Part A).

The Medicare Part B premium is not the same as the monthly premium charged by some prepayment plans. If a plan charges enrollees a premium, it is to cover Medicare's deductibles and coinsurance and to pay for extra benefits the plan may provide.

ARE THERE OTHER REQUIREMENTS TO JOIN A PREPAYMENT PLAN?

Yes. For example, you must:

- Enroll when the plan is accepting Medicare beneficiaries
- Live in the area served by the plan under its Medicare contract
- Have Medicare Part B (medical insurance)
- In most cases, receive all services through the plan except in an emergency
- Not have end-stage renal disease or undergone a kidney transplant in the recent past
- Not be receiving hospice care

WILL I ALWAYS HAVE THE SAME DOCTOR?

When you enroll, most prepayment plans allow you to select a doctor from those who are part of the plan. When you make an appointment, you usually will see the doctor you've selected. However, if you need to see a doctor quickly, and your selected doctor is busy, you may see another plan doctor. Also, you may change doctors within the plan, if you desire.

WHAT ABOUT SPECIALIST AND HOSPITAL CARE?

Prepayment plans use a full assortment of medical specialists. Generally, you must be referred to a specialist by your primary care physician if the plan is to cover the specialist's services.

WHAT IF I GET SICK AWAY FROM HOME?

When you're temporarily outside the plan's service area, the plan pays only for emergency or urgently needed medical care.

WHY JOIN A PREPAYMENT PLAN?

People join prepayment plans for many reasons. Some of the most frequently mentioned are:

- Various kinds of care needed are available through one source (for example, doctors' services, hospital care, laboratory tests, x-rays, etc.)
- You can budget health care costs because you know the premiums in advance, and other out-of-pocket expenses are predictable.

- There's no need to pay each time you need a service (this is true for most plans, although some may charge a nominal fee for individual services).
- Benefits beyond those covered by Medicare are available for no additional charge or a nominal charge at some plans.
- HMOs/CMPs reduce the amount of paperwork because you generally do not have to file any claims.
- HMOs/CMPs manage and coordinate the health care needs of their Medicare members.
- You may not need Medicare supplement ("Medigap") insurance.

ARE THERE ANY OTHER FACTORS TO CONSIDER IN DECIDING WHETHER TO ENROLL IN A PREPAYMENT PLAN?

Consider whether the plan is in a location convenient to you and whether adequate transportation is available to get you to the plan. Consider, too, that if you receive services outside the plan system, you may be required to pay additional fees, or even the entire cost of the services.

Medicare pays some plans for all your covered health care costs. Services received outside these plans, other than emergency or urgently needed services, are not paid for separately by Medicare, and cannot be billed to Medicare.

If you are considering enrolling in a prepayment plan, but are reluctant to do so because you have a longstanding and satisfactory relationship with your present doctor, ask whether your doctor is a participating physician in a plan. If your doctor is, then you may be able to enroll in the plan and continue to use his or her services. If your doctor is not affiliated with a plan, you may want to discuss with a plan representative how you will obtain health care if you join. Before enrolling, get information about the doctors available to serve you, the hospitals the plan uses, all auxiliary services, and your out-of-area coverage, as well as answers to questions pertinent to your individual situation.

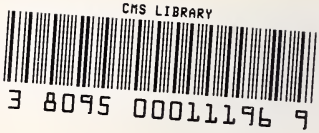
WHAT IF THE PREPAYMENT PLAN WON'T PAY FOR NECESSARY CARE?

If the plan refuses to pay for any service, or refuses to provide a covered service, and you believe it should pay for or provide the service, you have

guaranteed appeal rights under the Medicare law. These rights are explained in the health plan's description of its benefits and coverage. If you decide for any reason that you no longer want to be a member of the plan, you are free to disenroll. You may discontinue your membership at any time and return to "regular" Medicare effective the first day of the month after your written disenrollment request is received by the plan.

HOW CAN I FIND OUT MORE?

For more information about Health Maintenance Organizations or Competitive Medical Plans, contact your local Social Security office. Its staff can tell you of any prepayment plans with Medicare contracts in your area and how to get more specific information about them.



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